DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	E CONSTRUCTION 01, 02		(X3) DATE SURVEY COMPLETED	
		155802 B. W.				R 03/11/2016	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER				STREET ADDRESS, CITY, 1 SISTERS OF PROVIDE SAINT MARY OF THE	ENCE	03/11/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				
{K 000}	INITIAL COMMENTS		{K 00	00}			
	Paper compliance to Recertification and St conducted on 02/22/1 03/11/16.	ate Licensure Survey					
	Review Date: 03/11/1	6					
	Facility Number: 003 Provider Number: 15 AIM Number: 200429	5802					
{K 000}	Providence Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. INITIAL COMMENTS		{K 00	00}			
	Paper compliance to Recertification and St conducted on 02/22/1 03/11/16.	ate Licensure Survey					
	Review Date: 03/11/1	6					
	Facility Number: 003 Provider Number: 15 AIM Number: 200429	5802					
	compliance with Required Medicare/Medicaid, 4 Life Safety from Fire Rottonal Fire Protection	are Center was found in uirements for Participation in 2 CFR Subpart 483.70(a), and the 2000 Edition of the on Association (NFPA) 101, C), Chapter 18, New Health					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDENCE ROSUPPLIER PROVIDENCE HEALTH CARE CENTER STREETADORESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) [K 000] Continued From page 1 [K 000]			155802				1	
PROVIDENCE HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) [K 000] Continued From page 1 [K 000] Continued From page 1 [X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) [X5) COMPLETION DATE] [X6) CONTINUED FROM PROPRIATE DEFICIENCY]	NAME OF PF	ROVIDER OR SUPPLIER	10002		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2016
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [K 000] Continued From page 1 [K 000]	PROVIDEN	NTER						
	PREFIX	(EACH DEFICIENC)	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
						DEFICIENCY)		